This document will provide an overview of one of Tennessee's health care payment reform initiatives, Episodes of Care.

Tennessee Health Care Innovation Initiative

"It's my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers and payers. If Tennessee can do that, we all win."

– Governor Haslam's address to a joint session of the state Legislature, March 2013

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing physicians

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **sustainable medical costs and improving care**

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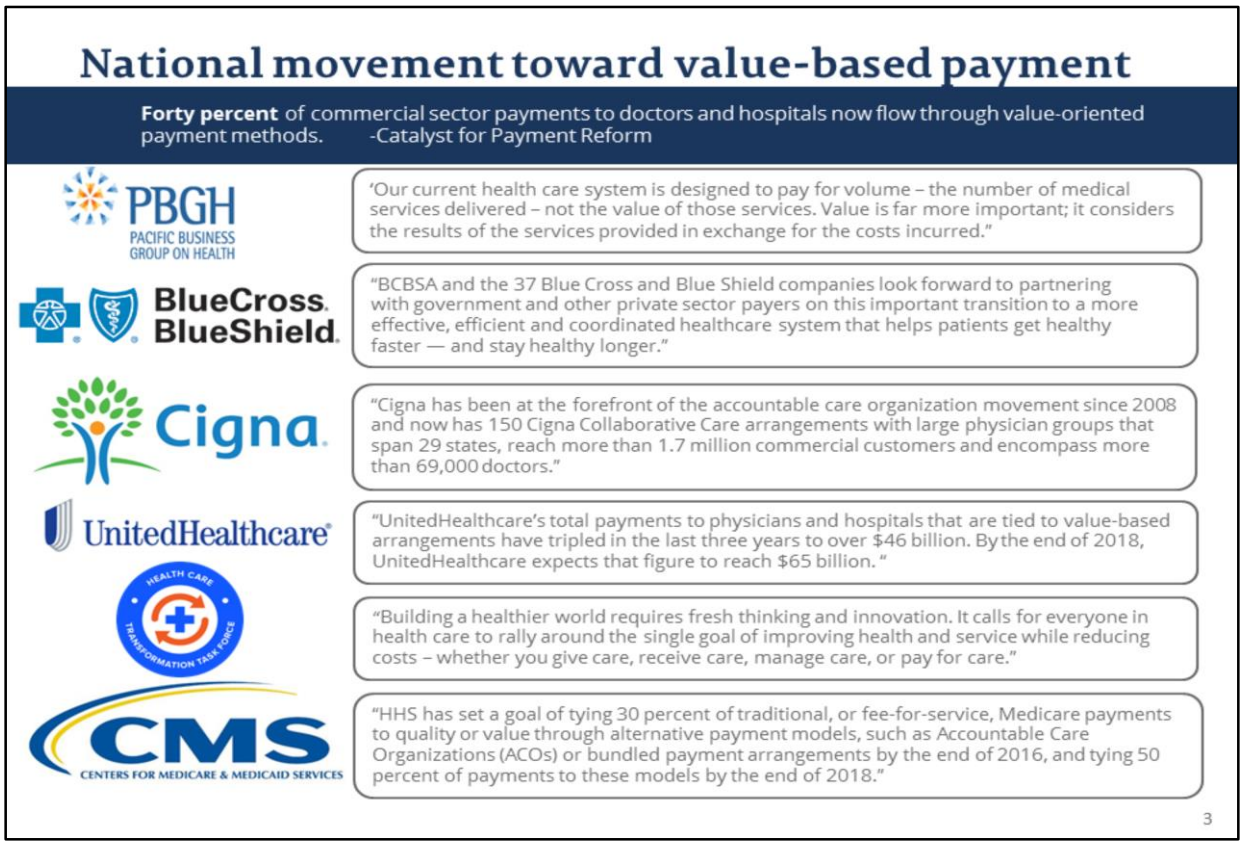
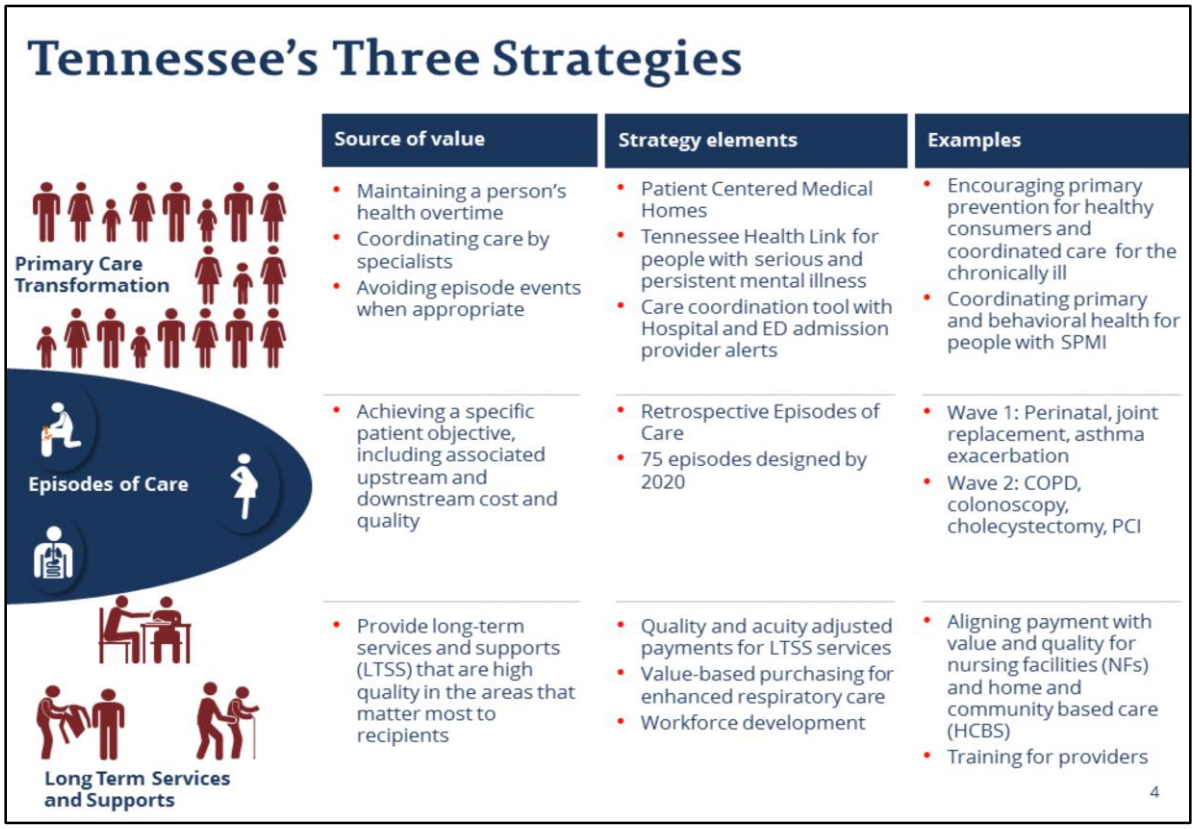
- In 2013, Governor Haslam launched Tennessee's Health Care Innovation Initiative with the goal to move from paying for volume to paying for value. Our mission is to reward health care providers for the outcomes we want including, high quality and efficient treatment of medical conditions, and maintaining people's health over time

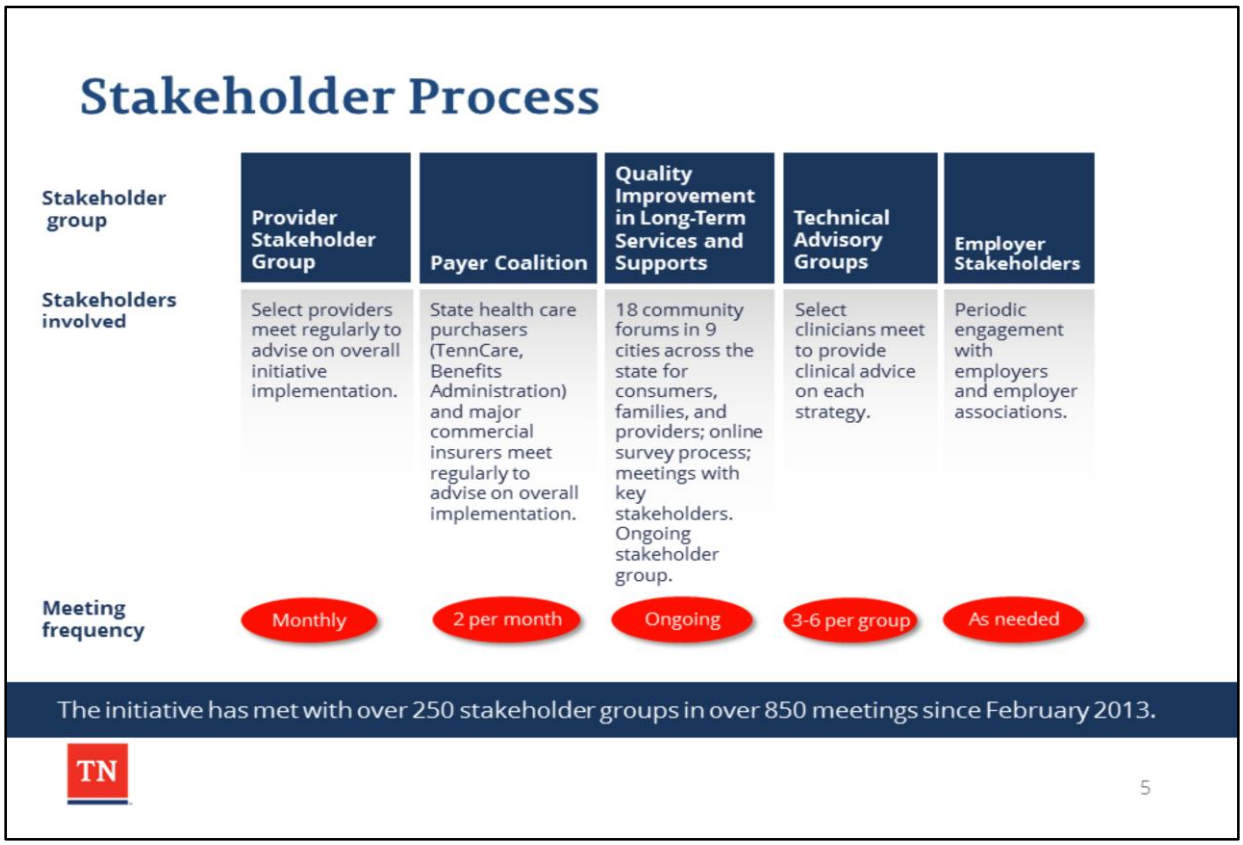
- Tennessee state government is leading by example as the largest purchaser of health insurance in the state. TennCare and our Benefits Administration for state employees both require participation in payment and delivery system reform in their health insurance contracts.



- Paying for value and paying for outcomes is a national trend in health care with significant momentum.
- Health care providers, insurance companies, employers, states, and the federal government are all changing incentives to reward the delivery of efficient, high quality care.
- There are many examples on this slide. For example, as of 2014, Catalyst for Payment Reform found that 40 percent of national commercial insurance utilized at least some value-based payment. This was a dramatic increase from 2013 when only 11 percent of commercial insurers used value-based payment.
- With all of the activity happening simultaneously, it can be a challenge for health care providers to participate. The quality measures of one value-based payment approach can be different from another, or the incentives can be tied to different things.
- In this context it is beneficial to health care providers in Tennessee that stakeholders are meeting and working together to align payment approaches where it matters most to the providers delivering health care services.



- Tennessee focuses on three specific strategies –primary care transformation, episodes of care, and long-term services and supports.
- Tennessee's strategies COMBINE to address most areas of health care.
- The first strategy is **Primary Care Transformation**. The primary care transformation component focuses on the role of the primary care provider: preventing illness, managing chronic illnesses, and coordinating with other providers.
    - This strategy includes patient centered medical homes (PCMH) for the general population of adults and children, a Tennessee Health Link model for TennCare members with high behavioral health needs, and a shared care coordination tool that brings additional information to primary care providers, including alerts to primary care providers when their patients go to the emergency room or the hospital.
- The second strategy is **Episode-Based Payments** which focuses on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization
    - Episodes encompass care delivered by multiple providers in relation to a specific health care event.
    - The episode-based component of payment reform seeks to reward providers who provide (and facilitate the delivery of) high quality, cost effective care over the course of an entire episode.
- The third strategy addresses **Long-Term Services and Support**. The state will implement quality- and acuity-based payment and delivery system reform for nursing facility services and home-and-community-based services. The initiative's approach will combine a quality measure framework focused on the member experience that is consistent across care settings.



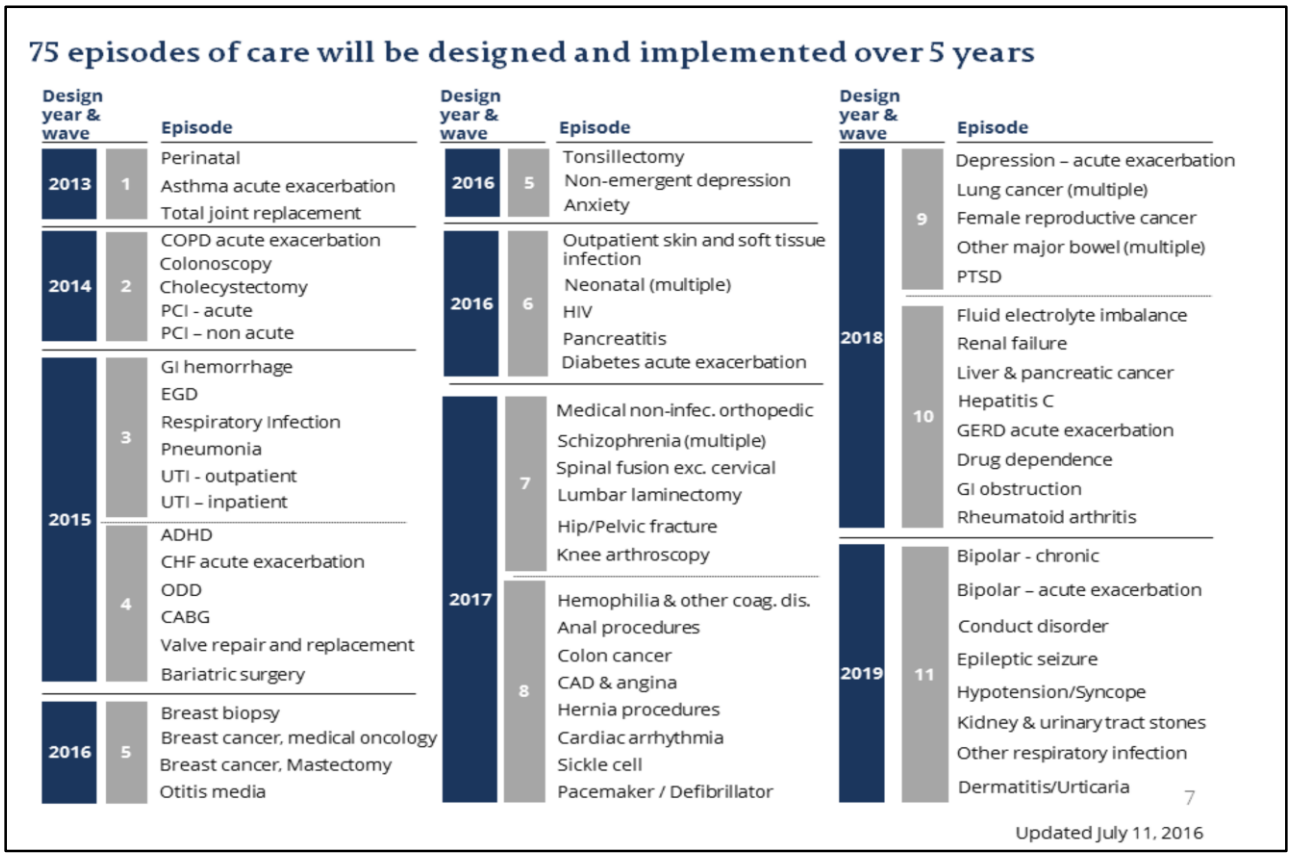
Stakeholder involvement is essential to designing all Episodes of care. Throughout the entire process, payers and providers are providing feedback to create a clinical sound and meaningful Episode of Care.

Tennessee is working in coalition with major insurers, providers, and other stakeholders. We have held over 400 meetings over the past two years to design and inform stakeholders about our strategies.

- **Technical Advisory Groups (TAGs)** are composed of Tennessee expert clinicians with relevant specialties who volunteer their time to make recommendations on the clinical design of episodes. These meetings are not open to the public. Members are selected through a nomination process. To learn more, please e-mail payment.reform@tn.gov.

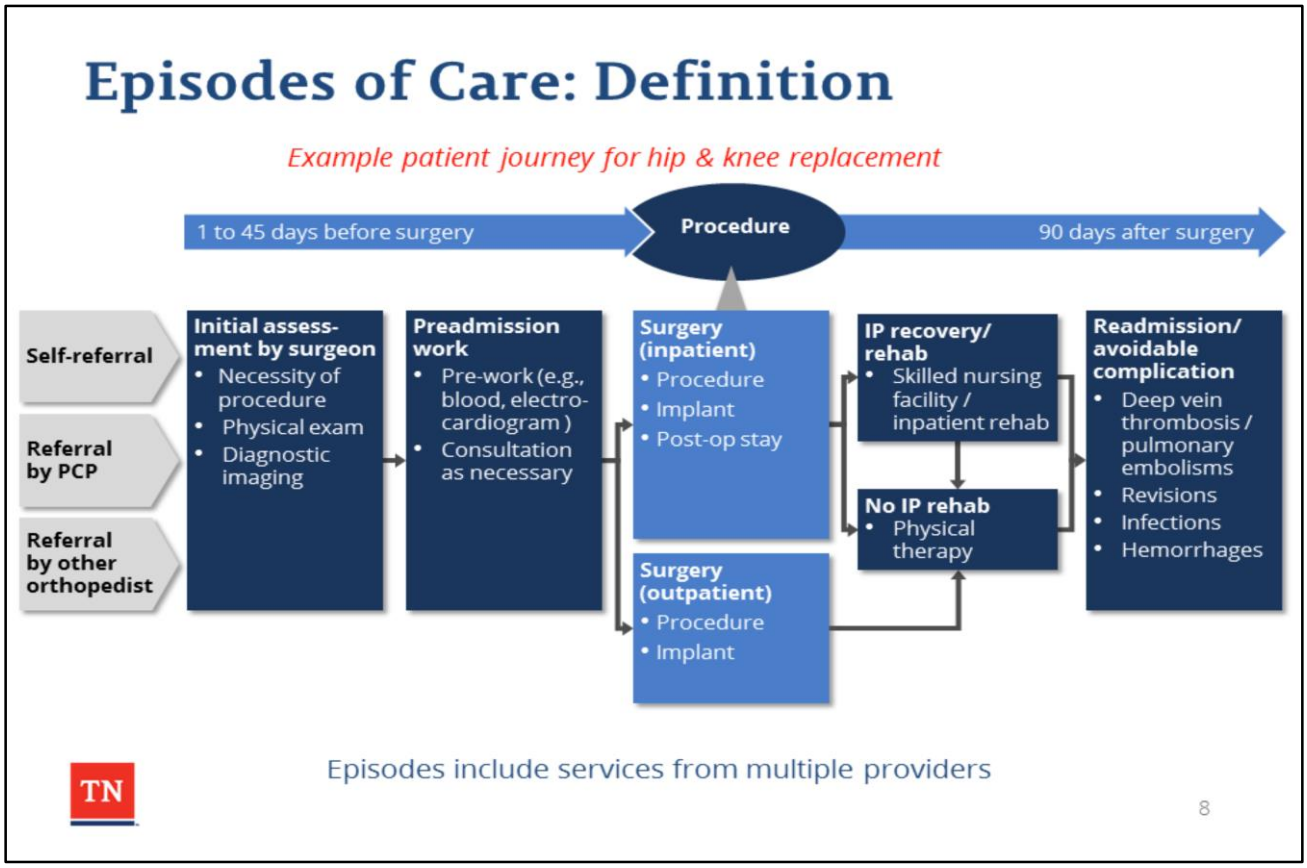
- **Annual Feedback Sessions** are an opportunity for the public to comment on what is working well with each episode's clinical design and where providers would suggest changes for next year. These meetings are open to the public.

Introduction slide to Episodes of Care



Tennessee aims to design and implement 75 episodes of care by 2019. The table lists all proposed episodes from 2013 to 2019.

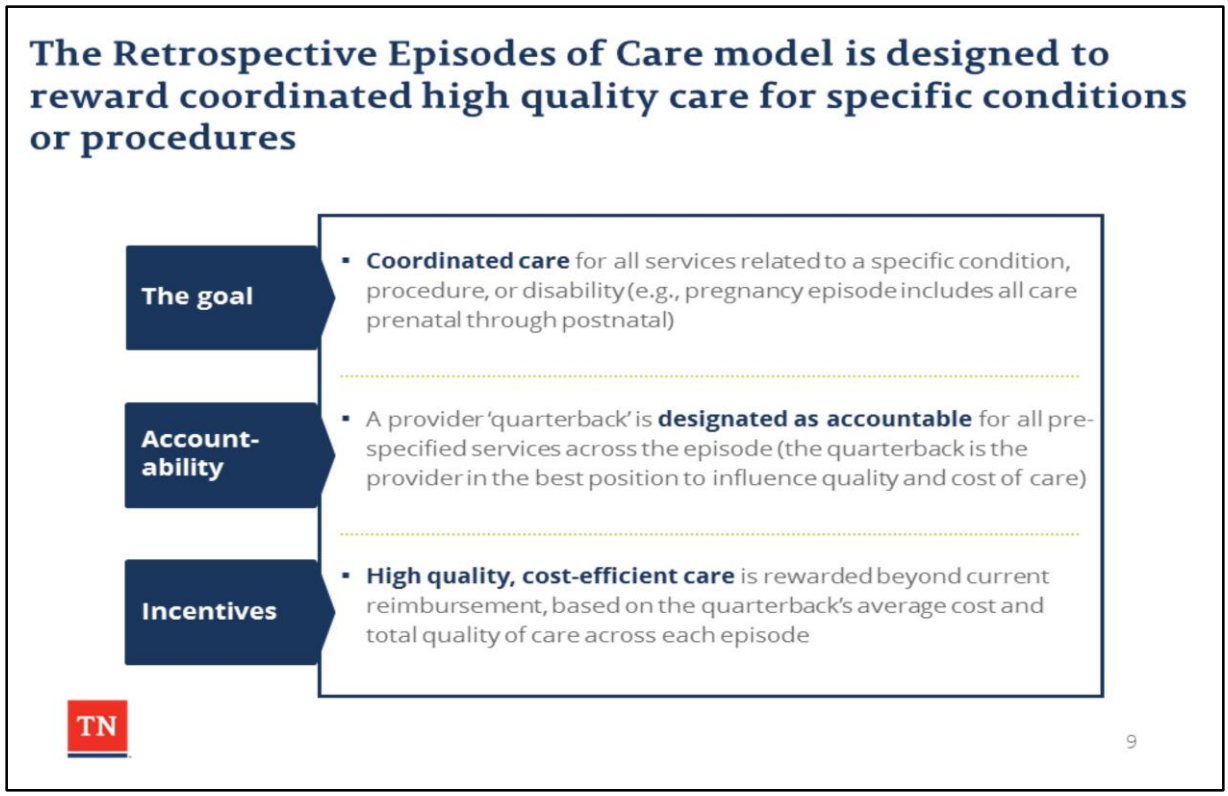
For episodes listed as “multiple,” create several episodes will be created based on specific conditions or diagnoses rather than on the broad diagnosis or condition.



- This slide depicts the Episode of Care (EOC) model.
    - Episodes of Care focus on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization.
- Episode-based payment seeks to align incentives with successfully achieving a patient's desired outcome during an “Episode of Care”, a clinical situation with predictable start and end points.

- Episodes of Care is a retrospective model, which means that the procedures and services included in the episode have already occurred. To better understand the EOC model, the total joint replacement (TJR) model is given as an example:
    - Each episode has a “Trigger” that initiates the start of an episode. For the TJR episode, the trigger is joint replacement surgery. This can either be inpatient or outpatient.
    - The episode can begin in multiple ways. In this example, it can come through self-referral, PCP, or another orthopedist
    - Each episode has an “Episode window” or the entire duration of the episode. For TJR, the episode window is from 45 days before surgery to 90 days after surgery.

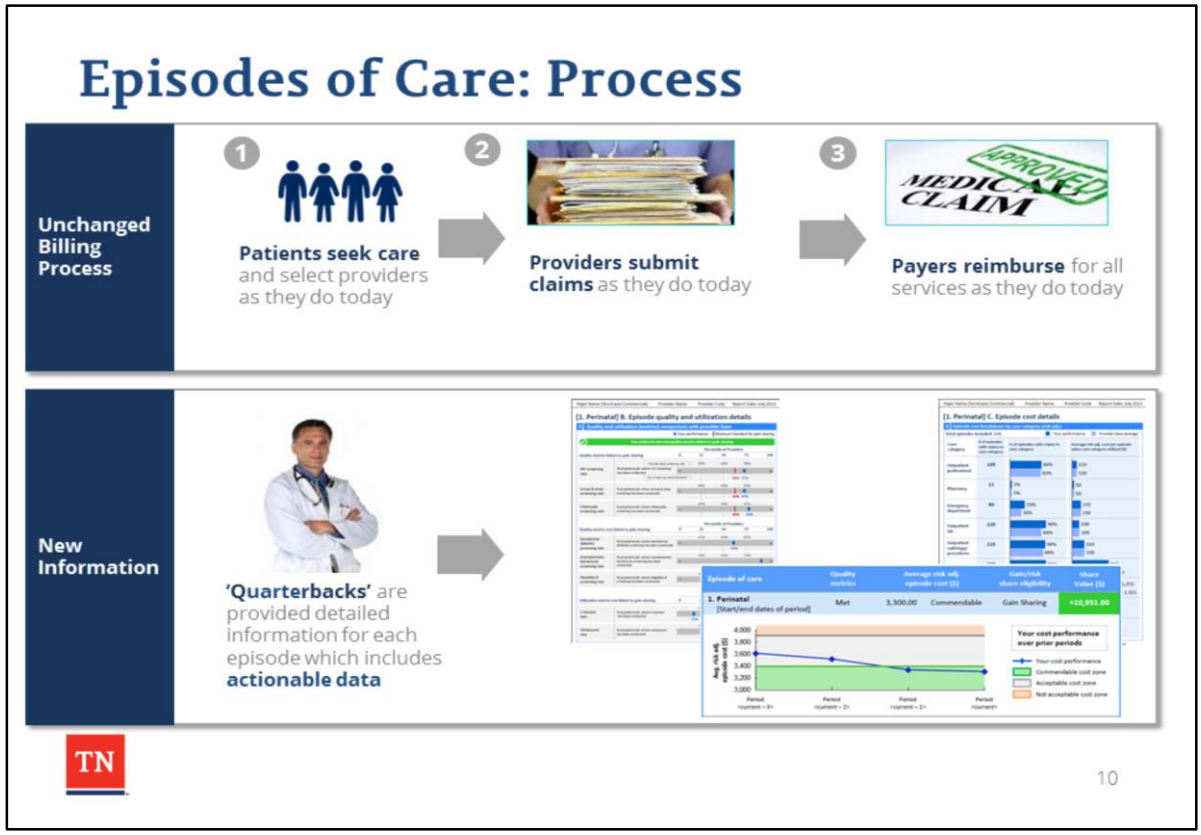
- EOC include services from multiple providers. In this case of the TJR episode, services such as diagnostic imaging, the implant, and rehab are included from three different points in time: before (pre-trigger window), during (trigger window), and after (post-trigger window) the procedure.
- Each quarter, the quarterback will receive a report detailing cost and quality of the care for that episode.



The Episodes of Care (EOC) model is designed to reward high-quality care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care.

The graphic displays three foundational principles of EOC:

- The goal of EOC is to encourage **care coordination** for all services related to a specific condition, procedure or disability.
- A "quarterback", either the physician or facility in the best position to influence quality and cost of care, is assigned to each episode and held accountable for the
- The quarterback is incentivized to provide **high quality and cost-efficient care** in order to be rewarded beyond current reimbursement.



Understanding the Process of Episodes of Care

- *[Unchanged Billing Process*] Episode-based payments do not require major changes in the organizational structure or administrative processes of the health care delivery system.
    - Patients seek care as they always have,
    - Providers involved in the episode submit claims as they always have, and
    - Providers are reimbursed as they are today

- *[New Information]* However, EOC does provider the Quarterback, either a facility, physician or group of physicians, with additional information as well as the opportunity to be rewarded for better results.
    - The term Quarterback is used because they are one player on the team of providers working with a patient to treat a condition. The Quarterback, however, is the provider who has the *best* chance to influence the overall *quality* and cost of the episode.

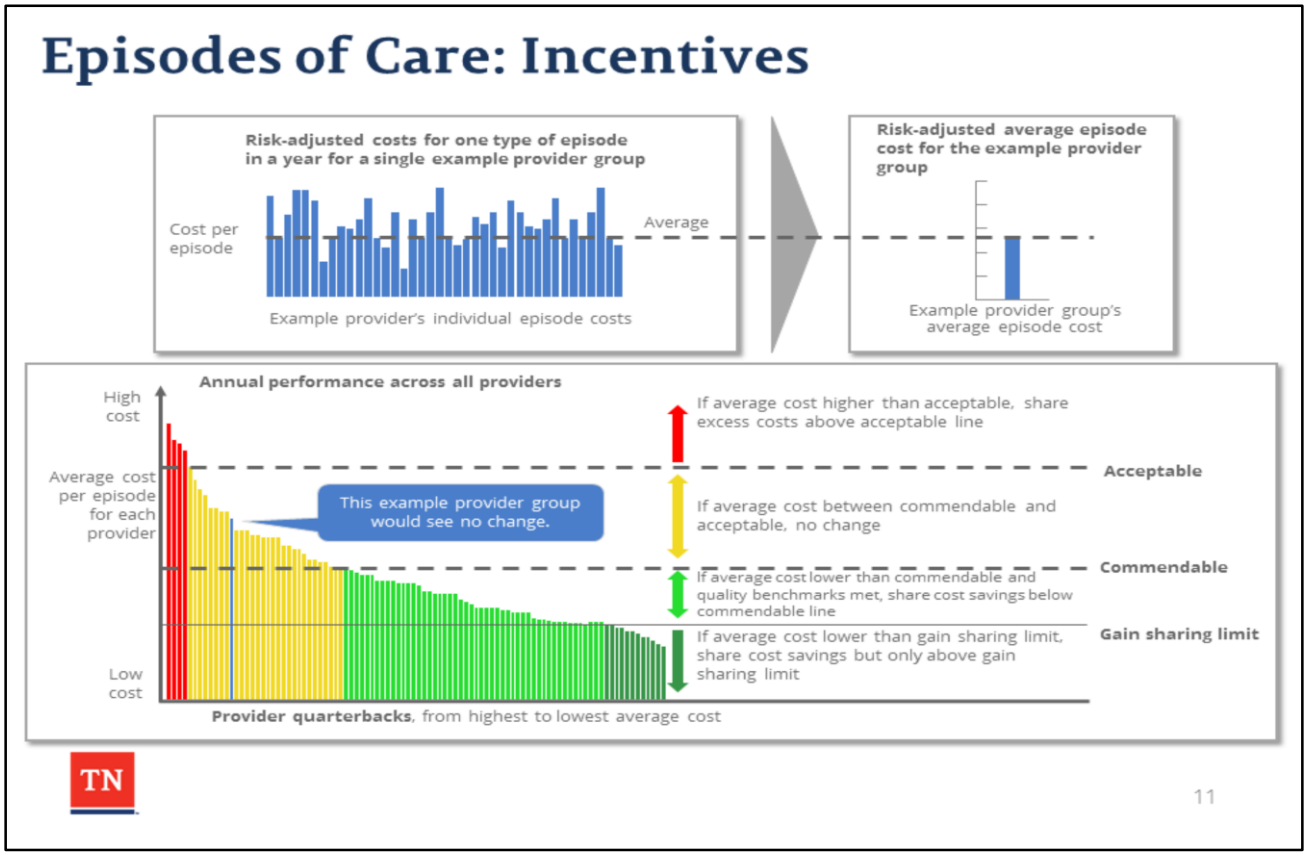
- Through EOC, the Quarterback will receive detailed information on each episode.
    - Information is broken down to allow the Quarterback to identify the particular components of the episodes that result in a significant deviation (positive or negative) from other providers.
    - Previously, providers only had information on what they billed for their services and what they were reimbursed by any given payer. Therefore, there was no insight into the cost of other components of the episode and little or no

information to tell the Quarterback how they compared relative to their peers in terms of quality and cost.

Episodes of Care Timeline: Preview and Performance Periods

- Each episode implementation will begin with a "Preview Period", during which Quarterbacks receive actionable data, including cost and quality for each of the episodes provided in that period. However, these reports are without financial liability and therefore allow the Quarterback time to adjust behavior to improve quality and outcomes.
    - Preview periods typically begin in May after the episodes are designed.

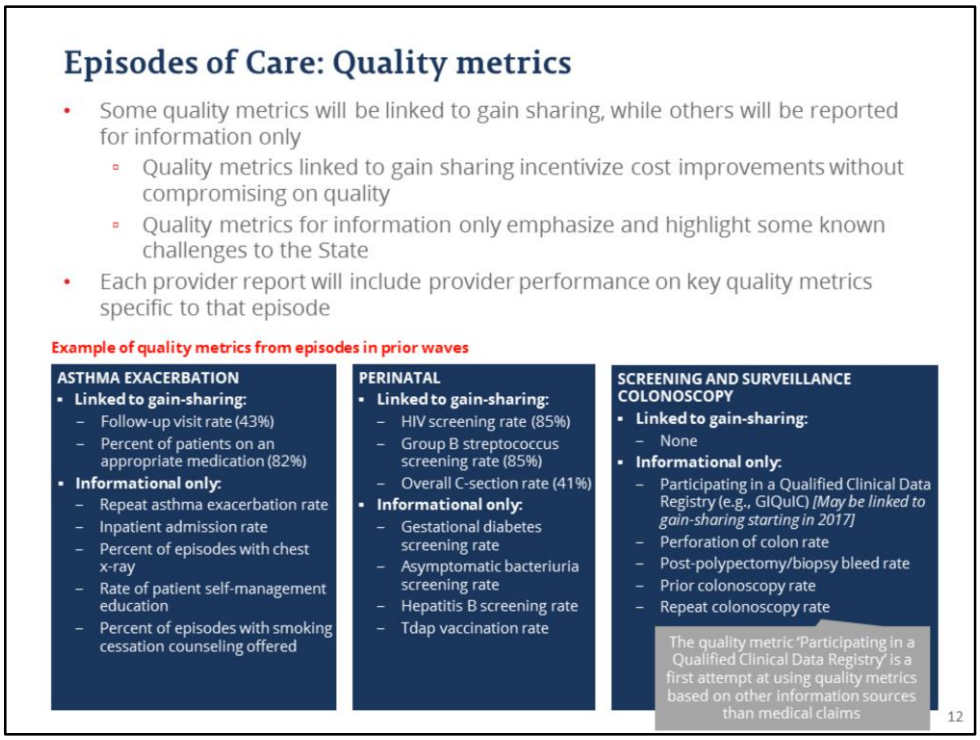
- After the Preview Period is completed, the "Performance Period" begins. Unlike the "Preview period", Quarterbacks are eligible for gain and risk-sharing based on their ability to effectively manage the total cost and quality of the care provided for all of their episodes.
    - The performance period is the calendar year following the year in which preview periods being. In August following the end of the performance period, high quality and efficient providers are rewarded for their high performance in the previous year. The high cost providers have a financial penalty for a share of the amount of costs that were over and above all of their peers.



- Over the course of a Performance Period, the Quarterback receives information on the cost of each Episode of Care that he or she has been involved with.

- The Quarterback's average risk adjusted episode cost is calculated and is represented as a blue bar shown above.

- The Quarterback's average cost per episode is plotted alongside the average cost of all the other Quarterbacks for that episode and compared to predetermined commendable and acceptable levels. Based on the results of that comparison, the Quarterback may:
    - Share in savings: if his average cost per episode is below the commendable level and quality targets have been hit;
    - Experience no change in pay: if his average cost per episode is between the commendable and acceptable levels; or
    - Pay part of the excess cost: if his average cost per episode is above the acceptable level.

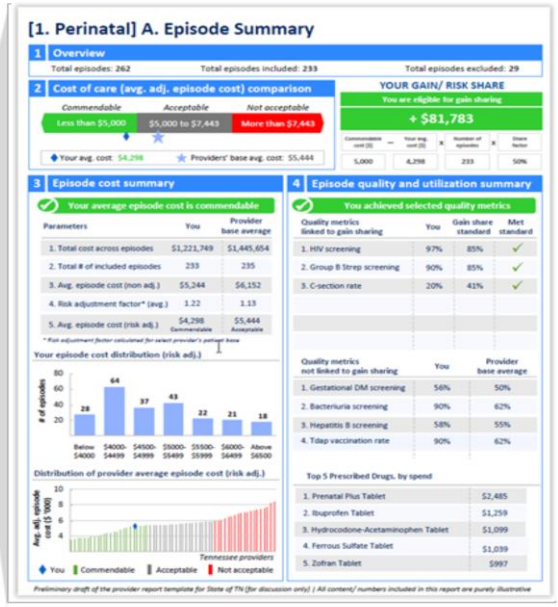


- For each episode, we have selected quality measures based on clinical input and practice guidelines. The provider reports will include performance on these key quality measures.
- Many quality measures can be based on claims data, which is the easiest way to measure quality.
- In cases where an important quality measure cannot be measured through claims, we are committed to bringing up non-claims based quality measures. For example, for the Screening and Surveillance Colonoscopy episode, participation in the GIQuIC registry will be tied to gain-sharing starting in 2017.

Episodes of Care: Reporting

Quarterbacks will receive quarterly report from payers:

- **Performance summary**
  - Total number of episodes (included and excluded)
  - Quality thresholds achieved
  - Average non-risk adjusted and risk adjusted cost of care
  - Cost comparison to other providers and gain and risk sharing thresholds
  - Gain sharing and risk sharing eligibility and calculated amounts
  - Key utilization statistics
- **Quality detail:** Scores for each quality metric with comparison to gain share standard or provider base average
- **Cost detail:**
  - Breakdown of episode cost by care category
  - Benchmarks against provider base average
- **Episode detail:**
  - Cost detail by care category for each individual episode a provider treats
  - Reason for any episode exclusions



- As mentioned previously, Quarterbacks will receive actionable data on a quarterly basis. With these reports, providers can compare their cost and quality results to other providers across the state.
  - Data includes summary key statistics like the number of episodes, average risk-adjusted episode cost, quality metric results.
  - The reports also include detail on each included and excluded episode a provider treats.
- These reports were developed with input from payer and provider stakeholders and will be consistent across payers.

Thank You

- Please email payment.reform@tn.gov with any questions or concerns.
- More information on the Tennessee Health Care Innovation Initiative:
  www.tn.gov/hcfa/section/strategic-planning-and-innovation-group
- More information on Episodes of Care:
  www.tn.gov/hcfa/topic/episodes-of-care

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